BATH COMMUNITY
PHYSICIANS GROUP

REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____

Patient's Legal Last Name: ______________________ First:_____________________________ MI:____

Is this your legal name? Yes___ No___

Street Address: ____ PO Box: __________________

City: ________________________________ State: _______ Zip Code: _____________

Home Phone (_____) - _____-_____Cell No: (_____) - _____-_____ Work Phone: (_____) - _____-_____

Primary Care Physician: _______________________________

Birthday _____/_____/____ Sex: Male_____ Female_____

Marital Status: ___________________________________ Social Security Number: _____-_____-_____

Employer: ________________________ Occupation: ________________ Phone: (_____) - _____-_____

Email: ____

Race: _____________________________________ Ethnicity: __________________________________

Language: _________________________________Pharmacy of Choice: __________________________

Insurance Company: ____

Policy Number: _______________ _____________Group Number: _______________ _______________

Insurance Subscriber: _______________________ Subscriber Date of Birth: ________________________

Guarantor Information (Complete Only If Other Than Patient):

Name: ____ Birthday _____/_____/____

Street Address: ____ PO Box: __________________

City: ________________________________ State: _______ Zip Code: _____________

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address):_________________________________

Relationship to Patient: ____

Home phone (_____) - _____-_____ Work phone (_____) - _____-_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Bath Community Physicians Group or my Insurance Company to release any information required to process my claims.

Patient/Parent/Guardian Signature: __________________________________ Date _____/_____/_____

PATIENT HIPAA ACKNOWLEDGEMENT AND CONSENT FORM

Patient Name:____ Date of Birth:____________________

_______(Patient/Representative initials) **NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my health care information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that that I may contact the Chief Compliance Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_______(Patient/Representative initials) **RELEASE OF INFORMATION**

I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other BHC affiliated facilities may be made available to subsequent BCH-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under Worker's Compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicare claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records, decreasing the time needed to access my information, aggregating and comparing my information for quality improvement purposes and such other purposes as my be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

DISCLOSURES TO FRIENDS AND/OR FAMILY MEMBERS

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, Findings and care decisions to the family members and others listed below:

Name	Relationship	Contact Number
1.		
2.		
3.		

PRESCRIPTION PICK-UP AUTHORIZATION

DO YOU WANT TO AUTHORIZE INDIVIDUAL(S) TO PICK UP YOUR PRESCRIPTIONS FOR YOU? IF YES, WHOM?

I hereby authorize the individual(s) listed below to pick up my prescription(s) for me at Bath Community Physicians Group. I understand that my agent/representative must provide valid photo identification each time he/she picks up my prescription(s). This authorization will remain active until I revoke it by contacting the staff at Bath Community Physicians Group.

	Name	Relationship	Contact Number
1.			
2.			
3.			

____ _________________________________

Patient/Representative Signature Date

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

Updated 5/2019

Bath Community Physicians Group Medication List Name: _________________________ Date of Birth ___/___/____

Name of Medication	Strength of Medication	How Often is Medication Taken

Jeffery McCray, D.O. Tamra Stall, M.D. Julie Monroe, D.O. Charles B. Lovelady M.D. FACS
Kimberly Rexrode, FNP Pamela Crance, FNP Richard A. Wall Jr., M.D.
Ann May FNP-C John Stapleton, FNP Elizabeth Armstrong, FNP-C
Hot Springs—PO Drawer Z, Hot Springs, VA 24445 / Phone: (540)-839-7197 Fax: (540)-839-4831
Covington—322 W Riverside Street, Covington, VA 24426 / Phone: (540)-962-1122 Fax: (540)-962-7881
Covington—713 S. Monroe Ave, Covington, VA 24426 / Phone: (540)-962-1122 Fax: (540)-962-7881
Millboro—432 Church Street, Millboro, VA 24460 / Phone: (540)-997-1447 Fax: (540)-839-4831

Health History Form

Today's Date _____/_____/_____

Name: ___________________________ ___________________________ ____ DOB: _____/_____/____
(Last) (First) (MI)

Please check any health conditions for which you are being treated:

_____High Blood Pressure

_____Heart Disease

_____Diabetes

_____Thyroid

_____Arthritis

_____Depression

_____Other (Please Specify) _______________

Past Medical History and Previous Illnesses:

____

____

Women Only:

Number of Pregnancies: _____________

Birth Control: ______________________

Date of Last Period: __________________

Last Complete Physical: ______________

Men Only:

Last Complete Physical: _________________

Health Maintenance History (leave blank if never)

Test:	**Date of Most Recent**:
Cardiac Catheterization	___/____/____
Colonoscopy	___/___/____
Dexa Scan	___/___/____
ECHO	___/___/____
EKG	___/___/____
Mammogram	___/___/____
Pap	___/___/____
Ultrasound Screening for AAA	___/___/____
Prostate Exam	___/___/____

Immunizations:	**Date of Most Recent**
Influenza (Flu)	___/___/____
Hepatitis A	___/___/____
Hepatitis B	___/___/____
Herpes Zoster(shingles)	___/___/____
Human Papillomavirus	___/___/____
MMR	___/___/____
Meningococcal	___/___/____
Pneumococcal	___/___/____
Tetanus, Diptheria, Pertussis(Tdap)	___/___/____
Tetanus, Diphtheria (Td)	___/___/____
Varicella (Chicken Pox)	___/___/____

Allergies:

List Food Allergies: _____________________________________Reaction: ____________________________

List Environmental Allergies: _____________________________Reaction: ____________________________

List Medication Allergies: ________________________________Reaction:____________________________

Past Surgeries & Dates

____
____
____

Hospitalizations:

____
____

Family History: (Mother, Father, Grandparents, Siblings)

Adopted____

Members	**Status** (Alive, deceased, or unknown)	**Age**	**Diabetes**	**Hypertension**	**Heart Disease**	**Stroke**	**Mental Illness**	**Cancer**	**Unknown**
Mother			☐	☐	☐	☐	☐	☐	☐
Father			☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather			☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother			☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather			☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother			☐	☐	☐	☐	☐	☐	☐
Siblings			☐	☐	☐	☐	☐	☐	☐

Social History:

Marital Status (circle one): Married Single Divorced Widowed

Number of Children: ____

Employer: ____________________________ Occupation: _______________________________

Tobacco (packs per day) ____ How many years: ___________________________

What Kind (circle one) Cigarettes / Cigars / Smokeless (Chewing tobacco and Snuff)

Alcohol (drinks per week)____	What Kind:_________________________________
Caffeine (cups per day) ____	What Kind (circle one) Coffee / Tea / Soda
Exercise (days per week) ____	Primary Form(s) ______________________________
Illicit Drugs: Yes ___ No ___	If Yes, what kind ______________________________

Bath Community Physicians Group complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Bath Community Physicians Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.